

Registration, Identification and Security of Newborn Infants Standard Operating Procedure

Issue Date	Review Date	Version
8 th December 2017	December 2022	1

Purpose

The purpose of this Standard Operating Procedure is to provide all clinical staff working within Maternity Services clear guidance

Who should read this document?

All midwives
All medical staff working within Maternity Services.

Key Messages

Maintenance of effective and safe patient care.

Core accountabilities

Owner	Sheralyn Neasham, Charlotte Wilton, Tracey Sargent
Review	Review date Clinical Effectiveness Committee, Women's & Children's Services
Ratification	Director of Midwifery
Dissemination	Director of Midwifery
Compliance	Director of Midwifery

Links to other policies and procedures

Local Maternity antenatal, intrapartum and postnatal guidelines
Postnatal guideline - Postnatal Care and transfer of women/baby.

Version History

1	Dec 2017	Conversion of guideline into Standard operating procedure
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The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

Section	Description	Page
1	Introduction	3
2	Definitions	3
3	Regulatory Background	3
4	Key Duties	4
5	Procedure to Follow	5
6	Document Ratification Process	8
7	Dissemination and Implementation	8
8	Monitoring and Assurance	8

Standard Operating Procedure (SOP)

Registration, Identification and Security of Newborn Infants Standard Operating Procedure

1 Introduction

There are various processes which should be followed within maternity services to ensure the safety of the newborn infant; these range from immediately following birth to care within the community setting. All staff working within maternity services should adhere to this standard operating procedure to ensure newborn security.

2 Purpose

This standard operating procedure is intended to identify the birth registration, identification and security processes to ensure neonatal patient safety and security from birth.

3 Regulatory Background

Security

All clinical areas must have locked doors with CCTV access via doorbell communication. All patients and visitors must be reminded of the restricted access and not allow other people through the doors without having spoken to a member of staff.

Recorded CCTV operates in maternity reception and is televised to CDS for additional security. The tapes are kept by security for 7 days in case they need to be reviewed.

The maternity entrance and all corridors leading to the general hospital are locked at night with regular security patrol. If the security doors are found to be unlocked at any stage; security and estates must be contacted to ensure immediate remediation of the problem.

All staff must carry combined identification and access to restricted area cards.

4.1. Birth Registration

Birth registration should be completed as soon as possible following delivery. The completion of the birth registration will ensure that an infant is issued with a hospital number and an NHS number.

Plymouth Hospitals NHS Trust use the PROTOS system which is interfaced with a central issuing system for NHS numbers. The midwife should enter the labour and birth details into the PROTOS system following delivery. It is important to check the 'referral' details prior to completing the 'inpatient administration' data; this ensures that barcoded screening labels contain accurate information such as GP details.

An infant will be issued with a hospital number and an NHS number following the completion of PROTOS. The PROTOS 'delivery document set' should be printed and distributed accordingly:

- Delivery summary in the pregnancy handheld notes
- Baby record part one in the baby main 'buff' notes
- One birth notification and one birth register beside the birth register book
- The remaining birth registers and birth notification will remain with the mothers
 - postnatal handheld notes for appropriate distribution upon discharge

NHS barcoded labels should then be printed from PROTOS and placed within the red child health record.

The details on the PROTOS delivery document set and the NHS barcoded labels should be checked for accuracy before filing.

4.2. Emergency Registration

In an emergency situation when an infant's hospital number is required immediately for clinical purposes, the midwife should:

- Contact maternity reception and request a hospital number for the baby
- Complete PROTOS as normal (the previously issued hospital number will
 - appear on the documentation).

5.1. Identification Following Birth

As soon as is practical after birth; two handwritten identification labels are attached to the neonate's ankles. Each label should bear the following information relating to the infant's mother – as recorded on her hospital notes:

- Baby of [mothers first name and surname]
- Neonatal date of birth
- Neonatal time of birth

The information on the labels must be checked with the mother against her own identification label prior to being attached to the infant.

Following birth registration (via PROTOS – see below) – the labels should be replaced with printed bar-coded labels that contain the baby's name, date of birth, NHS number and hospital number. In the event that printed bar-coded labels are unavailable; the two handwritten labels should remain on the infant's ankles.

For security reasons the infant's identity label must bear the name of the mother, even if he/she will be given the surname of the father at a later date. The information should be written in biro pen and not a roller ball or ink pen.

5.2. Information for Parents

The midwife who carries out the labelling procedure should make sure that the mother/parents are aware of the importance of the identification labels. The parents should be instructed that whilst in hospital they should check that two labels are present and correct every time they handle the infant, or following any period of separation. If one or both of the labels is missing or incorrect, they must inform midwifery staff immediately.

The parents should be advised that they may remove the identification labels following discharge from the hospital.

5.3. Checking Infant Identification in Hospital

The identification of mother and her infant should be confirmed by cross checking the information on their identification labels on the following occasions:

- On transfer from one ward area to another
- During routine daily neonatal examination
- Following any period of separation of the mother and her infant
- Prior to transfer out of hospital

The cross checking of maternal and neonatal identification labels should be documented in the neonatal notes.

5.4. If identification labels are missing or incorrect

If one of the infant's identification labels is missing:

- The information on the remaining identification label must be checked with the mother using her own identification label and obstetric notes (for date and time of birth).
- If this information is correct; a second label can be rewritten and checked with the mother before being attached to the infant.
- The ward manager or midwife responsible for the coordination of the ward must be informed.

5.5. If both of the infant's identification labels are missing:

- The identification labels of all other infants on the ward must be checked and counted by two midwives.
- After this check has been completed and all other infant labels are found to be present and correct the infant can be relabelled as per the procedure above.
- The ward manager or midwife responsible for the coordination of the ward must be informed.
- An incident form must be completed.

5.6. Additional Notes

If the mother is unable to participate in this procedure, it is acceptable for the midwife to check details with her partner or relative. If she is unaccompanied, the midwife should check all details with another midwife and document this fact in the notes or care plan.

It is particularly important that the identification procedure is correctly followed if the infant needs to be separated from his mother soon after delivery.

If the mother is having a general anaesthetic she needs to be aware that the infant identification labels will be checked with her partner or by two professionals.

In the case of multiple births, it is acceptable to attach a temporary identification label bearing mother's surname and e.g. 'Twin 1' **immediately** after delivery (to avoid confusion during resuscitation procedures). These must be replaced with permanent labels before the infant leaves the delivery room or theatre as per procedure above.

5.7. Infant in Nursery

The decision to separate a well baby from its mother should never be done as a routine procedure and should only take place with the agreement of the mother.

The midwife takes responsibility for any infants placed in the nursery and he/she must be satisfied that he/she can offer a safe level of supervision and care to any infant that he/she accepts.

When an infant is cared for in the nursery, the midwife must record in the infant's care plan;

- the reason that the infant was removed to the nursery.
- the time that he was removed.
- the time that he was returned to his mother.
- the fact that the label checking procedure was carried out on his removal and return.

5.8. Readmissions

All infants who return to the maternity unit for tests or examinations or because their mothers have been readmitted must be labelled. This will mean that all mothers readmitted because of their infant's condition will need to be labelled in accordance with local and Trust policy.

5.9. Infant's for Adoption

If a baby is to be adopted, all registration information should be completed in the normal manner.

In order to protect the woman's identity, the following steps must be taken when the baby is discharged from the maternity unit:

- The midwife caring for the baby (usually on TCW) must inform the PROTOS Co-ordinator (if weekend – PROTOS baby documents should be retained for attention on following Monday).
- The PROTOS Co-ordinator will remove all the woman's details from the baby documentation produced by PROTOS.
- A new PROTOS document will be provided with baby information only.

6 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the guideline committee and ratified by the Maternity Clinical Excellence Committee and the Director of Midwifery.

Non-significant amendments to this document may be made, under delegated authority from the Director of Midwifery, by the nominated author. These must be ratified by the Director of Midwifery and should be reported, retrospectively, to the Maternity Clinical Excellence Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

7 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director of Midwifery and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

8 | Monitoring and Assurance

It is expected that every episode of care to be clearly documented and as contemporaneously as possible using the approved maternity unit documents/paper work as per hospital policy. This is in line with standards set by professional colleges (NMC, RCOG). All entries must have date and time together with signature and printed name.